**PflegMed – Center for Integrative Medicine.**

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The practice of Integrative Medicine requires the understanding of clients: mind, body and spirit. Please take the time to fill out this intake form as completely as possible.

Today’s Date: \_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_ Zip Code \_\_\_\_\_\_

Email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact and phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred Pharmacy (regular and compounding): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Goals**: Please list the reasons you are here today and your goals for the visit.

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**Allergies:** Are you aware of any drug allergies? □ Yes □ No

If Yes, please list the drugs and the reaction you had: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Environmental Allergies?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Food allergies? Food intolerances? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medications:** Please attach a separate list if you have one or need extra space.

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| --- | --- | --- | --- |
| Name | Dose | How often | Year started |
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**Supplements:** Please be as specific as possible. Please bring supplements with you to your appointment.

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| --- | --- | --- | --- | --- | --- |
| Name | Manufacturer | Dosage | How many times per day | Why do you take it? | Year started |
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**Past Medical History**: Check all that apply

□ Allergies

□ Alzheimer’s

□ Anemia

□ Arthritis

□ Asthma

□ Bleeding disorder

□ Blood clot(s)

□ Breast disease

□ Broken bone

□ Cancer- Type: \_\_\_\_\_

□ Chronic Fatigue

□ Chronic Pain- Where: \_\_\_\_

□ Chronic Sinusitis

□ Depression

□ Diabetes

□ Diarrhea

□ Diverticulitis

□ Eczema

□ Emphysema

□ Endometriosis

□ Fibromyalgia

□ Gout

□ Heart Disease

□ Hepatitis

□ High Blood Pressure

□ High Cholesterol

□ Hypothyroidism

□ Impotence

□ Irritable Bowel Syndrome

□ Kidney Disease

□ Low Testosterone

□ Menopause

□ Migraines

□ Multiple Sclerosis

□ Osteoporosis

□ Panic Disorder

□ Prostate Enlargement

□ Reflux (GERD)

□ Seizures

□ Stroke

□ Urinary Tract Infections

□ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe your health as a child: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

General health \_\_\_\_\_\_\_\_\_\_\_\_ Food allergies \_\_\_\_\_\_\_\_\_\_\_\_\_

Frequent infections \_\_\_\_\_\_\_\_\_\_\_\_ Vaccinations ­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mono (EBV) \_\_\_\_\_\_\_\_\_ Strep infections (PANDAS/PANS) \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any history of:

Amalgams (mercury fillings, silver fillings)? □ yes □ no

Root Canals? □ yes □ no (if yes, how many? When?) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Exposure to Mold? □ yes □ no (if yes, when and how long \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

Concern for Lyme disease? □ yes □ no (if yes, when?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

Any implants? □ yes □ no (if yes, when, what kind? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

Emotional trauma? □ yes □ no (if yes, have you gone through EMDR? \_\_\_\_\_\_\_\_\_)

Traumatic life events? □ yes □ no (if yes, when: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

COVID: Have you had it? □ yes □ no or where you vaccinated? □ yes □ no

🡪When? \_\_\_\_\_\_\_\_ Did any of your complaints start around this time? □ yes □ no

**Past Surgical History**: List year performed next to the surgery. Fill in those not listed.

□ Appendix \_\_\_\_\_\_\_\_\_\_\_

□ Gallbladder \_\_\_\_\_\_\_\_\_

□ Tonsils \_\_\_\_\_\_\_\_\_\_\_\_\_

□ Sinus Surgery \_\_\_\_\_\_\_

□ Tubes in Ears \_\_\_\_\_\_\_\_

□ Hysterectomy: \_\_\_\_\_\_\_

□Total □ Partial

□ Tubal Ligation \_\_\_\_\_\_\_\_

□ Cardiac Bypass \_\_\_\_\_\_\_

□ Cardiac Cath \_\_\_\_\_\_\_\_\_

□ Spinal Fusion \_\_\_\_\_\_\_\_\_

□ Joint Replacement \_\_\_\_\_

Which joint:

□ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family Medical History:** To the best of your knowledge, have any blood relatives been diagnosed with the following. (Please state the family member(s) in the space provided):

□ Alcoholism \_\_\_\_\_\_\_\_\_

□ Allergies \_\_\_\_\_\_\_\_\_\_

□ Alzheimer’s \_\_\_\_\_\_\_\_\_

□ Anemia \_\_\_\_\_\_\_\_\_\_\_\_

□ Asthma \_\_\_\_\_\_\_\_\_\_\_\_

□ Bleeding disorder \_\_\_\_\_

□ Cancer \_\_\_\_\_\_\_\_\_\_\_\_\_

□ Depression \_\_\_\_\_\_\_\_\_\_

□ Diabetes \_\_\_\_\_\_\_\_\_\_\_\_

□ Epilepsy \_\_\_\_\_\_\_\_\_\_\_\_

□ Heart disease \_\_\_\_\_\_\_\_\_\_

□ High blood pressure\_\_\_\_\_\_

□ High cholesterol \_\_\_\_\_\_\_\_

□ Kidney Disease \_\_\_\_\_\_\_\_\_

□ Stroke \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Preventatives screening inventory** (with your Primary Care Physician, list results of last test):

|  |  |  |
| --- | --- | --- |
| Test | Year | Results |
| Women only: Mammogram |  |  |
| Women only: Pap Smear |  |  |
| Men only: PSA and digital rectal exam |  |  |
| Fasting lipid panel |  |  |
| DEXA/ bone density test |  |  |
| Carotid doppler |  |  |
| Cardiac stress test |  |  |
| Colonoscopy |  |  |
| Eye exam |  |  |

**Social History:**

**Tobacco**: □ yes □ no If yes, how many per day: \_\_\_\_\_ How many years: \_\_\_\_

Currently smoking: □ yes □ no If quit, how long ago: \_\_\_\_\_\_

**Alcohol**: □ yes □ no If yes, how many drinks per weeks: \_\_\_\_\_\_

**Drug use** (state which drug and if currently using): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who lives at home with you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How would you describe your home life? (Ex: open, loving, happy, mellow, dull, frustrating, tense, chaotic, safe, supportive, unhappy) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list your hobbies/interests: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Occupation- Please list what you do, how many hours a week and your level of satisfaction: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Has this or any job ever put you around strong chemicals or smoke? □ yes □ no

**Spiritual Life**: Having an active spiritual life or religious life if an important part of your overall health. Describe your current religious practice (Please use details: For example, do you attend church or other ceremony? Any small group studies?): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Stress:** Stress and the management of stress is very important to your overall health.

Describe the symptoms you feel when you are under stress and the activities or techniques you use to relieve stress: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Dietary Health:** Recall of dietary intake of the last 24 hours or pick a normal day.

Please list all the foods and drinks you have consumed in the previous 24 hours. (Include meals, snacks, beverages and condiments.)

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| --- | --- | --- |
| Food Item | Preparation (baked, fried, ect) | Amount (cup, tbs, oz, ect) |
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Is this a typical day? □ yes □ no

Servings of vegetables a day \_\_\_\_\_\_\_\_\_ Servings of fruit per day \_\_\_\_\_\_\_\_\_\_\_ **Caffeine intake**: How many cups per day of: Coffee \_\_\_ Tea \_\_\_ Decaf Coffee/Tea \_\_\_

Soda \_\_\_ Diet soda \_\_\_ Flavored water \_\_\_ Artificial sweeteners \_\_\_

**Review of Current Systems**: Please check any symptoms or concerns you have had in the last several months.

**Constitutional**

□ Good general health

□ Recent weight change

□ Headaches

□ Fever

**Ear/Nose/Throat**

□ Hearing loss or ringing

□ Earaches or drainage

□ Sinus problems

□ Nosebleeds

□ Bad breath or bad taste

□ Goiter

**Eye**

□ Eye disease or injury

□ Wear glasses or contacts

□ Glaucoma

□ Double/blurred vision

**Cardiovascular**

□ Chest pain or pressure

□ Palpitations

□ Shortness of breath lying flat

□ Swelling of extremities

**Respiratory**

□ Chronic or frequent cough

□ Shortness of breath

□ Asthma or wheezing

□ Coughing up blood

**Energy**

□ Forgetful

□ Poor concentration

□ Fatigue- Worst time of day: \_\_\_\_\_\_\_

**Gastrointestinal**

□ Loss of appetite

□ Nausea or vomiting

□ Diarrhea

□ Painful bowel movement

□ Constipation

□ Cramping

□ Bloating

□ Rectal bleeding

□ Blood in stools or black stools

□ Abdominal pain

**Hematology**

□ Bleeding or bruising

□ Anemia

□ Past transfusion

**Genitourinary**

□ Frequent urination

□ Painful urination

□ Blood in urine

□ Change in force of urine

□ Female – irregular menses

□ Pelvic floor problems

**Neurological**

□ Frequent headaches

(related to menses? \_\_\_\_\_)

□ Light-headed/dizzy

□ Numbness/tingling

□ Tremors

□ Head injury

**Musculoskeletal**

□ Joint pain

□ Joint stiffness/swelling

□ Weak muscles or joints

□ Muscle pain or cramps

□ Back pain

□ Difficulty in walking

**Skin**

□ Hives

□ Rash or Itching

□ Varicose veins

**Psychiatric**

□ Memory loss/Confusion

□ Nervousness/Anxiety

□ Depression/Mania

**Breast**

□ Masses

□ Pain/ Tenderness

□ Prior abnormal mammograms

**Endocrine**

□ Excessive thirst/urination

□ Sugar cravings

□ Hot/cold intolerance

□ Poor sex drive

□ Dry skin

□ Hair loss

□ PMS symptoms

□ Post-menopausal bleeding

□ Hot flashes

**Sleep**

□ Problems falling asleep

□ Problems staying asleep

□ Snoring

□ Restless legs

**Menstrual and Pregnancy History (women only):**

□ Number of pregnancies \_\_ Live births \_\_ Living children \_\_ Abortions \_\_ Miscarriages \_\_ Last Menstrual Period \_\_\_\_\_ Last pelvis and PAP exam \_\_\_\_ Last mammogram \_\_\_\_ Are your periods normal \_\_\_ How long are they? (28, 29 30) \_\_\_ days

Abnormal flow \_\_ Abnormal pain \_\_ List all forms of birth control \_\_\_\_\_\_\_\_\_\_\_\_

Are you looking to getting pregnant in the next few years? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Sleep Inventory:**

Are you satisfied with the quality and quantity of your sleep? □ yes □ no

Do you wake up in the middle of the night? □ yes □ no At what time? \_\_\_\_\_\_\_

Are you able to go back to sleep if you wake up? □ yes □ no

Are you tired or sleepy during the day? □ yes □ no

Do you snore? □ yes □ no

Have you had a sleep study before? □ yes □ no If yes, results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Previous Complimentary Experience:**

□ Acupuncture

□ Biofeedback

□ Breathwork

□ Chiropractic

□ Guided Imagery

□ Homeopathy

□ Hypnotherapy

□ Iridology

□ Massage

□ Meditation

□ Naturopathy

□ Qi Gong

□ Reflexology

□ Reiki

□ Yoga

What things have you tried already for your specific complaints (conventional or alternative)?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list anything you would like to discuss today: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_